



ADMINISTRATIVE ASSESSMENT OR REFERRAL

ND DEPARTMENT OF HUMAN SERVICES

CHILDREN AND FAMILY SERVICES

SFN 1920 (8-2003)

County Name:	County Number:	Date of Report:	Case Number:
Reporter:		Code for Relationship of Reporter to Child(ren):	Telephone Number:
Report Received by: <input type="checkbox"/> Phone <input type="checkbox"/> Office Visit <input type="checkbox"/> Mail			
Regarding: Name(s) of Child(ren)		Name(s) of Subject(s)	

A. REASON FOR ADMINISTRATIVE ASSESSMENT

1. <input type="checkbox"/> Concerns clearly fall outside the state law. (if not CPS but report involves a foster care family or child care provider, consider giving report to licensing, letting reporter know) Explanation:	
2. <input type="checkbox"/> Reporter can give no credible reason for suspecting a child has been abused or neglected. Explanation:	
3. <input type="checkbox"/> Insufficient information to identify or locate the child. Explanation:	
4. <input type="checkbox"/> There is reason to believe the reporter is willfully making a false report. Explanation:	Referred to State's Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain:
5. <input type="checkbox"/> Report in which the concern is/was being addressed in a current/prior assessment. Explanation:	
6. <input type="checkbox"/> Concerns addressed in report are being dealt with in treatment at HSC or through case management at CSSB. Explanation:	
Therapist, county and Regional CPS involved in decision: <input type="checkbox"/> Yes <input type="checkbox"/> No If no: Explain:	

(OVER)

<p>7. <input type="checkbox"/> Assessment Terminated in Progress (AT). Explanation: _____</p> <p>Documentation Attached: <input type="checkbox"/> Addendum <input type="checkbox"/> Log of Contacts</p> <p>Contacts: <input type="checkbox"/> Collateral <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) <input type="checkbox"/> Subject</p>	<p>Referred to State's Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Pregnant Woman</p> <p>8a <input type="checkbox"/> Alcohol Abuse</p> <p>8b <input type="checkbox"/> Controlled Substance Use</p> <p>8c <input type="checkbox"/> Both</p> <p>8d <input type="checkbox"/> Neither</p> <p>Documentation attached: <input type="checkbox"/> Log of contacts <input type="checkbox"/> Activity record <input type="checkbox"/> Narrative <input type="checkbox"/> Records</p>	
<p>Referred for Mental Health Commitment: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contacts: <input type="checkbox"/> Collateral <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) <input type="checkbox"/> Subject</p>	

B. REASON FOR REFERRAL

<p>1. <input type="checkbox"/> The child(ren) of the report is not physically present in the county receiving the report. Referred To: _____</p> <p>Explanation: _____</p>	
<p>2. <input type="checkbox"/> Report of non-caregiver sexual abuse or non-caregiver physical abuse referred to law enforcement for disposition. Referred To: _____</p> <p><input type="checkbox"/> Assistance offered to law enforcement.</p>	
<p>3. <input type="checkbox"/> Child(ren) of report is on an Indian reservation and assessment is the responsibility of the tribal government or BIA. Referred To: _____</p>	

C. NOTIFICATION (Must be completed for Part A or Part B),

<p>Subject of report notified about the report: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____</p>	
<p>Reporter notified of action: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____</p>	
<p>Reporter or subject referred to other services: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

REVIEWER'S SIGNATURES	DATE
County: _____	
County: _____	
Region: _____	
Date Received at Regional Office: _____	